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Medical misogyny

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From wandering wombs to the missing clitoris: How medical misogyny works

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Medical misogyny has a long history. ARTWORK: ADOBE STOCK IMAGES DIGITALLY ALTERED BY MARIJA ERCEGOVAC

This story is part of our investigative series on medical misogyny in Australia, exploring its impact and sharing solutions to address it. [See all 11 stories.](#)



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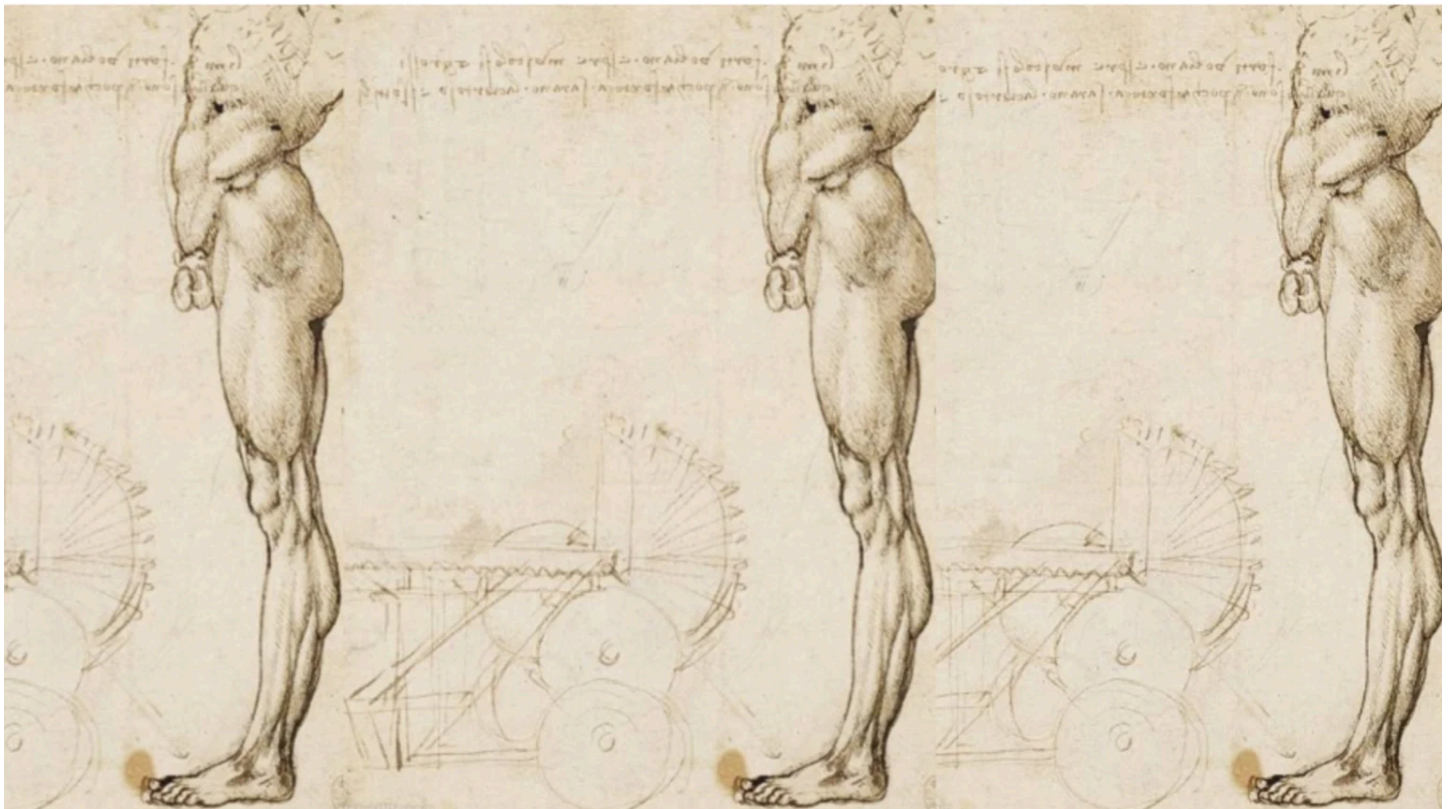
22 min

Bronwyn Graham is dwarfed by three colossal sketches of a naked male body from hip to heels. She points to a penis as long as her forearm.

“Who knows what this is?” she asks to ripples of laughter from the crowd in the Sydney auditorium for the Festival of Dangerous Ideas.

“As far back as the year 1500, Leonardo Da Vinci was drawing startlingly accurate anatomical sketches of the male penis,” says Graham, the director of the Centre for Sex and Gender Equity in Health and Medicine at The George Institute.

“Now, who can tell me what this is?” Graham says, and a giant plush pink clitoris appears on the screen behind her.



Leonardo da Vinci's anatomical sketches from the 1500s. LEONARDO DA VINCI

It would be another 500-odd years before the clitoris was fully mapped by Australian Dr Helen O'Connell in 1998. The urologist made medical history in her downtime. An unfunded, after-hours hustle (more on this later).

“How was it that an entire body part was missing from anatomy books right up to the 20th century?” Graham asks. The answer is simple.

“It is rather difficult to find the clitoris ... on a male body,” Graham says. “For centuries, scientists have viewed the male body as the status quo as the truest representation of what it is to be human.”

Systemic gender bias is as old as medicine itself. The discrimination women experience as a result of their sex (biology) and gender (social norms) has been ingrained in medical research, training and practice that treats male bodies as the ideal and female bodies as aberrations: faulty, defective and deficient.

In the fourth century BC, Aristotle described the female body as the inverse of the male body, with its genitalia “turn’d outside in” – a mutilated male.

The myths about the way women express and tolerate pain have been ingrained in medicine for centuries.

Countless accounts from women who had been dismissed, belittled, misdiagnosed and gas-lit led *The Sydney Morning Herald* and *The Age* to launch an investigation into medical misogyny.

But where did this phenomenon first take root? How has it thrived?

“At every stage in its long history, medicine has absorbed and enforced socially constructed gender divisions,” says feminist cultural historian Dr Elinor Cleghorn in her book *Unwell Women*.

Medical misogyny is a phenomenon that has evolved with every shift in cultural norms and, like so much of medicine, all roads lead back to Hippocrates.

The wandering womb

Imagine your uterus as a wild animal constantly hungering for sex, and you are the unwitting vessel at the mercy of its insatiable appetite. The only surefire way to tame this beast is to weigh it down with a baby.

This was the view of the ancient Greeks, who believed a uterus not otherwise preoccupied with procreating would prowls around a woman’s body, wreaking havoc on her, causing pain, violent fits, fainting and hallucinations.

This “wandering womb” could rob moisture from the liver, constrict the heart, get stuck under the ribcage and squash the diaphragm, suffocating a woman to death.

Hippocrates, considered the father of medicine, is [credited with coining the term “hysteria”](#) in the fifth century BC from one of the Greek words for the womb – the organ responsible for a woman’s principal function: to bear children.

For this reason, Hippocratic physicians were fixated on the womb as the source of all diseases in women.

Plato, in the fourth century BC, described the womb as a voracious “animal which longs to generate children” that became “vexed and aggrieved” if its sexual impulses to conceive went unheeded.

Mad, bad or dangerous

The ancient Greeks forbade autopsies but, despite physicians eventually realising the uterus was fastened in place by ligaments and tissue, the idea women were possessed by an organ that hungered for sex and children persisted for thousands of years.

Hysteria was the most commonly diagnosed female malady in the 18th and 19th centuries, and the link between madness and the uterus was a “scientific fact”, says Jane Ussher, professor of women’s health psychology at Western Sydney University.

Hysteria described every conceivable mental and physical symptom afflicting women that was even slightly difficult to explain. It was applied to difficult women, women deemed to be too sexual or who grated against society’s expectations of their domestic, childbearing roles.

“So many women were imprisoned, and I use the word ‘imprisoned’ literally, in lunatic asylums in the 19th century because they wanted an independent life,” Ussher says.

Women diagnosed with hysteria could exhibit symptoms of depression, rage, nervousness, crying, chronic tiredness, eating disorders, speech disturbances, paralysis, palsies and disabling pain. Many women also exhibited a hysterical fit, which could either come on gradually or could occur suddenly, mimicking an epileptic seizure, Ussher says.

To the physicians of the 18th and 19th centuries, the brain and reproductive organs were closely linked. Sickness in one affected the other.

Elizabeth Comen, in her book *All in Her Head*, tells the story of 19th-century Boston physician Horatio Storer, who treated a woman who was married to an older man and had a higher libido than her husband. Storer diagnosed the woman with nymphomania and recommended she be committed to an asylum. He also condemned his wife to an asylum for “catamenial mania” (menstruation-induced insanity).

By 1883, French physician Auguste Fabre had declared: “All women are hysterical and ... every woman carries with her the seeds of hysteria.”

“The womb and the woman were pathologised and seen as mad, bad or dangerous,” Ussher says. Menstruation, pregnancy, menopause and breastfeeding were all aberrations to be distrusted.

It was a diagnosis almost exclusively applied to middle- and upper-class women who could afford to follow hysteria treatments, most notably the “rest cure”, famously portrayed in Charlotte Perkins Gilman’s gothic horror book *The Yellow Wallpaper* in which a woman was confined to a nursery by her physician husband after she suffered a “nervous depression” following the birth of their baby.



Jane Ussher, senior lecturer and researcher at Western Sydney University. JAMES BRICKWOOD

You can see echoes of hysteria in modern medicine. Studies investigating medical bias have shown women are more likely to be offered antidepressants or sedatives before pain medication when their pain cannot immediately be attributed to a physical cause and is assumed to be psychological or emotional rather than caused by an underlying disease.

‘We have them at our mercy’

One of the true villains in the history of medical misogyny was a 19th-century London gynaecologist and obstetrician, Isaac Baker Brown, who forged a career mutilating women in his puritanical crusade to cure hysteria.

Brown pioneered ovariectomy (amputation of the ovaries) and attempted to popularise clitoridectomy (surgical removal of the clitoris glans). Many of his patients died on his operating table.

Brown was expelled from the Obstetrical Society in 1867, not so much for his barbarism but his fame-hungry publicity at a time when obstetricians were trying to establish themselves as an elite profession, Gabrielle Jackson wrote in *Pain and Prejudice*.

At the meeting of the all-male Obstetrical Society confirming Brown’s ousting, the society’s vice president, Sir Francis Seymour, delivered the most poignant example of medicine’s paternalism: “We are, in fact, the stronger, and they, the weaker ... they are not in a position to dispute anything we say to them, and we, therefore, may be said to have them at our mercy.”



One of Jean-Martin Charcot's public exhibitions at Paris' Salpetriere Hospital Asylum, 1887. WIKIMEDIA COMMONS

Hysterical queens

Another infamous chapter in hysteria's history is French neurologist Jean-Martin Charcot's public exhibitions at Paris' Salpetriere Hospital Asylum.

Physicians, socialites and celebrities would watch as he hypnotised his infamous hysteric "queens" who would faint, shriek, contort, crawl on all fours and rock nonexistent babies in their arms as Charcot attempted to unearth past emotions that he believed caused their hysteria.

"If you look at photos of hysterics from the 19th century, it is all very objectifying and fetishising," Ussher says.



A hysterical patient of Jean-Martin Charcot in 1850, photographed as part of the collection 'Hystéro-Épilepsie Contracture'. GETTY MUSEUM COLLECTION

Hysteria may have predominantly been an affliction of white European women, but black, Indigenous and other ethnically diverse women were and are among the most vulnerable to medical misogyny.

In the 1840s, Scottish physician James Young Simpson championed anaesthesia during childbirth for the “civilised female”, believing upper-class women were particularly sensitive to pain, Cleghorn writes. There was no need to offer working-class women anaesthesia, given their higher pain tolerance, and black women were almost impervious to pain – a belief that helped justify slave labour.

One of the most egregious historical cases is the medical research conducted by James Marion Sims, considered by some to be the father of modern gynaecology in the late 19th century. Sims used enslaved black women as unconsenting test subjects for experimental invasive surgeries without anaesthesia.

Then there's the case of Henrietta Lacks, a 31-year-old African American woman whose cervical cancer cells were taken without her consent in the 1940s and would become the first, and for many years, the only, immortal human cell line, known as HeLa.

The HeLa cell line has been used in laboratories worldwide and has contributed to myriad scientific breakthroughs from cancer (including cervical cancer), microbiology and infectious disease to space travel and COVID vaccines. Researchers spun HeLa into lucrative and lauded careers while Lacks died poor and in pain.

Diagnosing depressed housewives

In the post-World War II period, drug companies landed on a promising target for antidepressant pills: middle- and upper-class women. Unsatisfied with life as a housewife, overwhelmed by the crippling expectations of raising children and oppressed by the weight of traditional gender roles? Here's a quick fix.

In the 1950s, tranquillisers like Miltown (meprobamate) were marketed as the miracle cure for anxiety, depression, nerves, fatigue and low libido.

White, middle-class women who had discovered new, relative economic and political freedoms during World War II had more educational and employment opportunities but were buckling under the pressure of maintaining motherhood and homemaking, Cleghorn says. Pharmaceutical companies seized on this "paradox of femininity" and pathologised it.

"The new cultural stereotype of the anxiously unwell housewife fuelled the production of benzodiazepines like Valium, Librium and Serax in the 1960s," Cleghorn says.



Henrietta Lacks' cervical cancer cells were taken without her consent. ORIGINAL UNKNOWN

**You can't set her free.
But you can help her
feel less anxious.**

You know this woman.
She's anxious, tense, irritable. She's felt this way for months.
Beset by the seemingly insurmountable problems of raising a young family, and confined to the home most of the time, her symptoms reflect a sense of inadequacy and isolation. Your reassurance and guidance may have helped some, but not enough.
Serax (oxazepam) cannot change her environment, of course. But it can help relieve anxiety, tension, agitation and irritability, thus strengthening her ability to cope with day-to-day problems. Eventually—as she regains confidence and composure—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.
May be used in a broad range of patients, generally with considerable dosage flexibility.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Abasia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

Serax[®]
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa.

A 1967 advertisement for Serax (oxazepam), a highly prescribed anti-depressant in the postwar period.

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

Advertisements for psychotropic drugs were heavily aimed at women and ensuring control over the housewife's subservience, Ussher says.

One 1967 ad for Serax featured a woman imprisoned behind mop and broom handles with the tagline, "You can't set her free. But you can help her feel less anxious."

Women's asthma, gastrointestinal disorders and any unexplained chronic pain or neurological symptoms were chalked up to psychosomatic symptoms to be treated with anti-anxiety medication.

Drug companies and clinicians have been accused of retrofitting psychiatric diagnoses to push prescriptions for decades, and echoes of hysteria ring through modern psychiatry today.

"Hysterical neurosis" was only deleted from the Diagnostic Statistical Manual (the DSM – known as the US psychiatrists' bible) in 1980 and, Ussher argues, was replaced by other amorphous diagnoses, most notably borderline personality disorder (BPD), a highly contentious mental illness overwhelmingly diagnosed in women.

"It is described as the 'dustbin disorder' used to dismiss and pathologise women who don't fit the norm of femininity of how women are supposed to be," Ussher says.

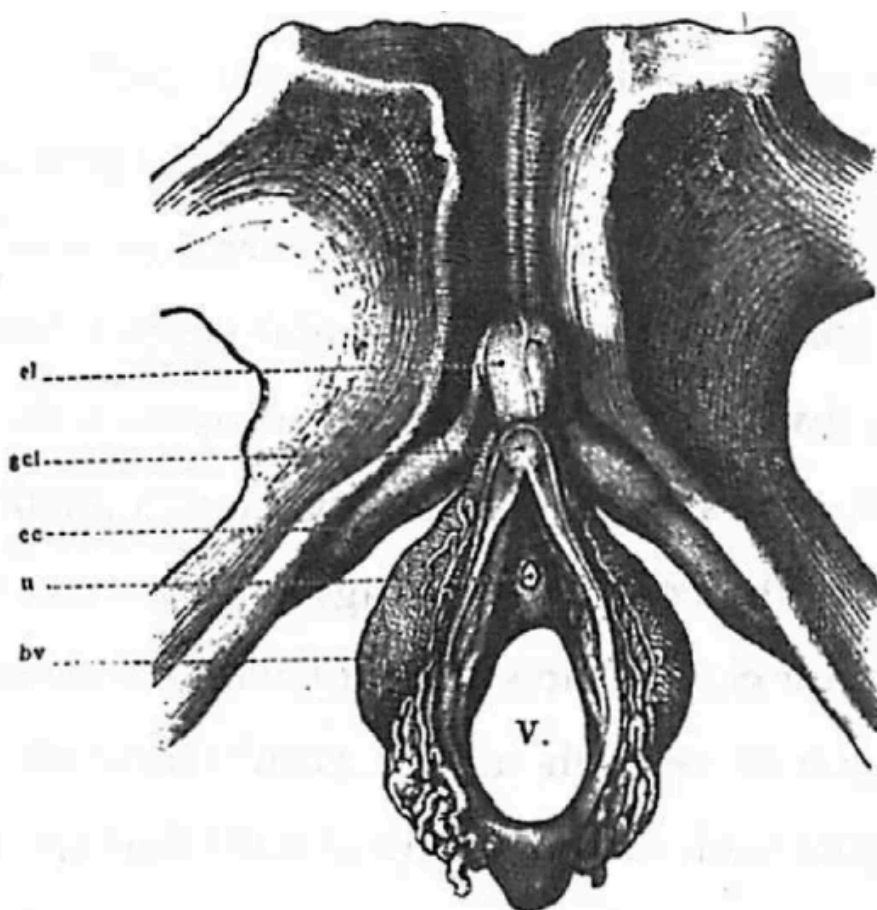
Many women diagnosed with BPD have traumatic histories, with high rates of child sexual abuse, Ussher says. "Rather than seeing them as mad [their symptoms are] an understandable response to what has happened to them."

The missing clitoris

Medical diagrams in the 16th to 18th centuries often depicted the female reproductive system as the inverse of male genitalia, just jammed inside the body. Then there's the great disappearing clitoris.

In the 1840s, German anatomist Georg Kobelt published detailed drawings of the female genitals. By 1948, all mention of the clitoris had been scrubbed from the 25th edition of the seminal *Gray's Anatomy* textbook, only to re-emerge in later editions as nothing more than its small, externally visible glans.

It wasn't until 1998 that Dr Helen O'Connell rewrote modern medical books by [mapping the entire](#) clitoris, proving it was not just a pea-sized button (glans) but an expansive organ with a wishbone-shaped body and eggplant-shaped bulbs with nerves, blood vessels and connective tissue.



Helen O'Connell's work built on the groundbreaking 1840s anatomy and "really beautiful" drawings of Georg Kobelt. GEORG LUDWIG KOBELT

"There is an assumption that misogyny is wilful," O'Connell says, but "medical misogyny seems to be due to a lack of awareness rather than conscious maltreatment".

For Graham, what is striking about O'Connell's work is that she did it unfunded in her spare time – a common theme in women's health research.

Take the female brain. Only in the past decade have we discovered the brain fundamentally changes its structure following pregnancy.

“That work was [done by a neuroscientist in Spain](#) – Dr Elseline Hoekzema – over a decade just drip-feeding women through the MRI scanner, unfunded,” Graham says.

“You’ve got the clitoris, a fundamental part of the body not mapped until 1998, and you have the brain following pregnancy, an almost ubiquitous female experience not known until 2017,” she says.

Clinical trials

It wasn’t until 1993 that the US Food and Drug Administration and the National Institutes of Health (NIH) mandated the inclusion of women in clinical trials. In the years prior, health and drug regulators banished from clinical trials any female of childbearing potential (any woman who had not gone through menopause) for fear of harming their fertility.

Australia and Britain are among many countries that do not mandate the inclusion of females in medical research.



Professor Bronwyn Graham at the 2024 Festival of Dangerous Ideas in Sydney.

“This only came about because a small body of people were pointing out that ‘Hey, there are no females here’,” Graham says. “The fallout is that women’s healthcare is based on a man’s body.”

As a result, women are 50 per cent more likely to experience adverse reactions to drugs and vaccines compared with men. Pain medication and anaesthetics are not as effective in women.

“The increased rates of female participation [in recent years] are often driven by breast cancer research and gynaecological cancers. When you look at conditions that affect everybody,

women still have lower participation rates,” Graham says.

Aside from the fact that the medical research field has been male-dominated, the historical exclusion of women from clinical trials is based on two flawed and mutually exclusive beliefs.

The first is that no sex or gender differences exist in health beyond conditions that affect the reproductive organs, so trial results from an all-male cohort are generalisable to female patients. The second is that females will produce more variable data because of fluctuating hormones.

“They completely undermine each other, but nobody has made that connection,” Graham says.

“Researchers didn’t want their data contaminated by menstrual cycles or menopause,” Ussher says.

It is a die-hard myth that women are more variable than men.

“There have been a lot of studies that have compared variability in data between males and females that consistently shows, from rats through to humans that there are no sex differences in the variability of data,” Graham says.

“One thing people forget is that men also have hormones that fluctuate daily. But hormones are only one factor contributing to variance in data for women and men.”

Medical research doesn’t begin with clinical trials. Pre-clinical studies almost exclusively use male animals and male cell samples. It wasn’t until 2016 that the NIH mandated that any pre-clinical trials awarded research funding must include female animals.

“I was doing research on all-male rats throughout my PhD on anxiety disorders at the same time that I was training to be a clinical psychologist seeing 90 per cent of women, and I didn’t make the connection,” she says.

Medicine’s gender-neutral problem

If you open a medical textbook, chances are you’ll find anatomical illustrations of human body parts. Male body parts. Unless it’s a part that men don’t have, specifically female reproductive organs.

“The default is male,” Graham says. “The default heart, the default lung are depicted in a male body.”

Medical students are taught medicine in a predominantly gender-neutral way, but the evidence base is predominantly male, Graham says.

“They are being taught implicitly that the way that you treat people and the way that disease manifests and their trajectory is the same for males and females because they are not being told otherwise,” Graham says.

“If we can’t get the fundamentals of sex studied, how do we begin to consider gender, innate variations in sex characteristics [and] sexual orientation?”

“This is bad for men too because it means we are not giving tailored treatments to men either, and we are not recognising when symptoms are typically male versus typically female.”

This sex blindness has slowed advancements in medicine with disastrous consequences.

A reckoning

The past few years have marked a mainstream awakening to medicine’s gender bias. Its critics are out in force, from Jackson’s *Pain and Prejudice*, to Cleghorn’s *Unwell Women* and Comen’s *All in Her Head*.

In 2015, when Jackson and her colleagues at *The Guardian* asked endometriosis sufferers to share their experiences, she received more than 600 responses within 24 hours.

“Women wait longer for pain medication than men, are more likely to have their physical symptoms ascribed to mental health issues, and are more likely to have their heart disease misdiagnosed, become disabled after stroke, suffer from illnesses ignored or denied by the medical profession, and wait longer to be diagnosed with cancer,” Jackson wrote in *Pain and Prejudice*.

After her own endometriosis diagnosis, Jackson was angry at the doctors who misdiagnosed or dismissed her for years.

“[But] I soon realised that the situation we’re in isn’t because of a few doctors being sexist. Like many examples of shocking sexism the problem is structural and not easy to solve,” she wrote.

Jackson quoted US endometriosis campaigner and advocate Mary Lou Ballweg: “Until the group that is affected stands up and says, ‘Enough already!’ it will not stop.”

The full-throated advocacy of women who have been failed by medicine is a powerful force.

What is being done in Australia?

In Australia, passionate and sustained pressure from endometriosis sufferers and their families – spearheaded by advocacy organisation EndoActive – got the attention of the then health minister Greg Hunt in 2019, which led to the first instalment of unprecedented funding towards prevention, early detection and treatments as part of a National Women’s Health Strategy.

In 2024, the Labor federal government introduced longer Medicare-funded specialist consultations for endometriosis, which affects about one in nine Australian women.

Women who spent years in debilitating pain dismissed by doctors are responsible for the Victorian government’s decision to [launch the Inquiry into Women’s Pain in 2024](#), including Premier Jacinta Allan, whose endometriosis went undiagnosed until her early 30s when she was

struggling to conceive. The final report and recommendations are expected to be published early this year.

In NSW, women who experienced birth trauma and their midwives led the charge to establish the Birth Trauma Inquiry, which heard harrowing testimonies from thousands of women. As a result, [NSW Health Minister Ryan Park issued an apology](#) and promised to speed up the delivery of five initiatives, including providing trauma-informed training for healthcare workers, improving the provision of information to enable women to be involved in decision-making and giving informed consent for birth interventions, and to better support women who experienced pregnancy complications.

The federal Assistant Minister for Health and Aged Care, Ged Kearney, did not shy away from calling women's experiences in healthcare "medical misogyny" when she announced in 2023 that she would chair a national Women's Health Advisory Council.

"The bias against women in the health system is deeply entrenched," Kearney says. "We are now bringing together experts to begin to peel back the layers so we can chart a different course."

The council is due to release its "End Gender Bias" report early this year and will undertake an audit of the Medicare rebate system to investigate why rebates are higher for procedures for men, such as scrotal ultrasounds, than they are for procedures for women, such as internal ultrasounds.

It's a global problem

Several countries have either implemented or plan to mandate gender equality in healthcare. For instance, in the European Union, the Gender Equality Strategy (2022-25) aims to ensure that healthcare systems are free of gender discrimination, in particular the scarcity of women in clinical trials.

Meanwhile, the World Health Organisation and the United Nations are increasingly focused on addressing sex and gender discrimination in healthcare that disproportionately affects minority groups across race, class and disability.

There is also a growing movement towards greater efforts to produce gender-disaggregated data to track healthcare outcomes for women, and the #MeToo in Medicine campaign has helped expose medical misogyny on a global scale.

"Now, more than ever, we need medicine to face up to its history," Cleghorn wrote in *Unwell Women*. "We are the most reliable narrators of what is happening in our own bodies. The lives of unwell women depend on medicine learning to listen."

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